portions of bone could be so badly contused by traumatism as to become necrosed and separated through inflammatory processes. 4. There is an idiopathic dissecting osteochondritis which, without noteworthy injury to a joint, gives rise to separation of portions of joint surface. A large number of cases of movable bodies in joints, until now believed to be traumatic in their origin, have arisen in this way. 5. The etiology of this supposed pathologico-anatomical process is at present unknown.

Malignant Tumors of the Upper Jaw.

Dr. W. T. Helmuth reports (*Annals of Surgery*, December, 1887) five cases from which he believes the following clinical deductions may be drawn, without regard to the microscopic examination:

1. Giant-celled sarcomas (myeloid tumors) are prone to affect the upper jaw more frequently than any other malignant growths. 2. The subperiosteal tumors are in their early stage difficult to diagnose from the ordinary epulis. 3. Sections of the latter are much firmer than the former and contain more fibrous tissue. 4. Cut surfaces of myeloid growths resemble very closely sections of bits of marrow or suet. 5. Myeloid tumors do not bleed readily—in fact, can be handled almost with impunity so far as bleeding is concerned. 6. The integument covering sarcomas of the jaw does not infiltrate, marking a strong clinical contrast in this respect to carcinoma. 7. The integument covering sarcomas of the jaw is liable to inflame, and suppuration and ulceration to ensue from distention and pressure of the diseased mass beneath. This complicates the diagnosis. 8. The fibroid epulis is liable to degenerate and at each recurrence to become more malignant. 9. In the majority of cases sarcomas of the upper jaw are very liable to destroy life, death generally occurring from asthenia. 10. The earlier and more complete the excision the longer the period of immunity.

OTOLOGY.

UNDER THE CHARGE OF

CHARLES H. BURNETT, M.D.,

PROFESSOR OF OTOLOGY IN THE PHILADELPHIA POLYCLINIC AND COLLEGE FOR GRADUATES IN MEDICINE, ETC.

Chronic Suppurative Otitis Media.

In a paper of this title, read at the meeting of the Otological Section of the American Medical Association, June, 1887, Dr. S. S. Bishop, of Chicago, seems to start out with an erroneous impression as to the true form in which the so-called "dry treatment" is to be carried out.

Your reporter has never yet seen any authority recommend hermetical closure of the external auditory canal by means of insufflated powders. Yet this asserted feature in the treatment is constantly brought forward by those who desire to condemn the method of dry treatment, which really consists in gently dusting or insufflating just enough powdered boric acid to cover lightly the exposed mucous membrane of the drum cavity and the membrana tympani.

No good can be obtained by tamponing the external ear with any substance; it has never been recommended by any authority on otology; and no bad result has ever arisen from the gentle and conservative use of insufflated boric acid, or boric acid with iodoform (one of the latter to seven of the former), as has been fully explained by numerous authorities. If the method will be misunderstood or misrepresented, those who approve of it have nothing to do with confuting false conclusions drawn from erroneous premises.

TREATMENT OF OTORRHŒA WITH POWDERED BORIC ACID.

DR. L. STACKE, of Erfurt (*Deutsche med. Wochenschrift*, December 8 and 15, 1887), very justly claims that in some cases of acute otitis media, after either spontaneous or surgical perforation of the membrana tympani, the insufflation of boric acid in powder, or of any other powdered substance, is not well borne by the inflamed mucous membrane of the middle ear.

Antisepsis of the middle ear in acute suppuration cannot be carried out like antisepsis elsewhere in the body, on account of the resentment shown by the mucous membrane of the tympanic cavity to the ordinary antiseptic fluids.

Insufflations of boric acid in powder act best in large perforations of the membrana tympani, because they can then better reach the diseased mucous membrane, and there is also less danger of clogging the drum cavity and engendering retention of pus.

In perforations of the membrana flaccida or Shrapnell's membrane, with purulent disease of the attic of the tympanic cavity, powder insufflations are insufficient treatment. In such cases the tympanic syringe must be inserted into the perforation and the attic washed out with carbolic acid solutions (2½–5 per cent.), or with peroxide of hydrogen, and *not* by means of syringing from the meatus, as the writer suggests, after "widening the perforation with the galvanocautery." If this will not meet the indications, the carious malleus may be excised.

Insufflations of powdered boric acid accomplish most in those cases "with little secretion; large perforations in the membrana vibrans; smooth, ungranulating mucous membrane; and absence of disease of the bone, or any symptoms of retention of pus."